

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH-16 50M 1/81
(VRA 15, 4)

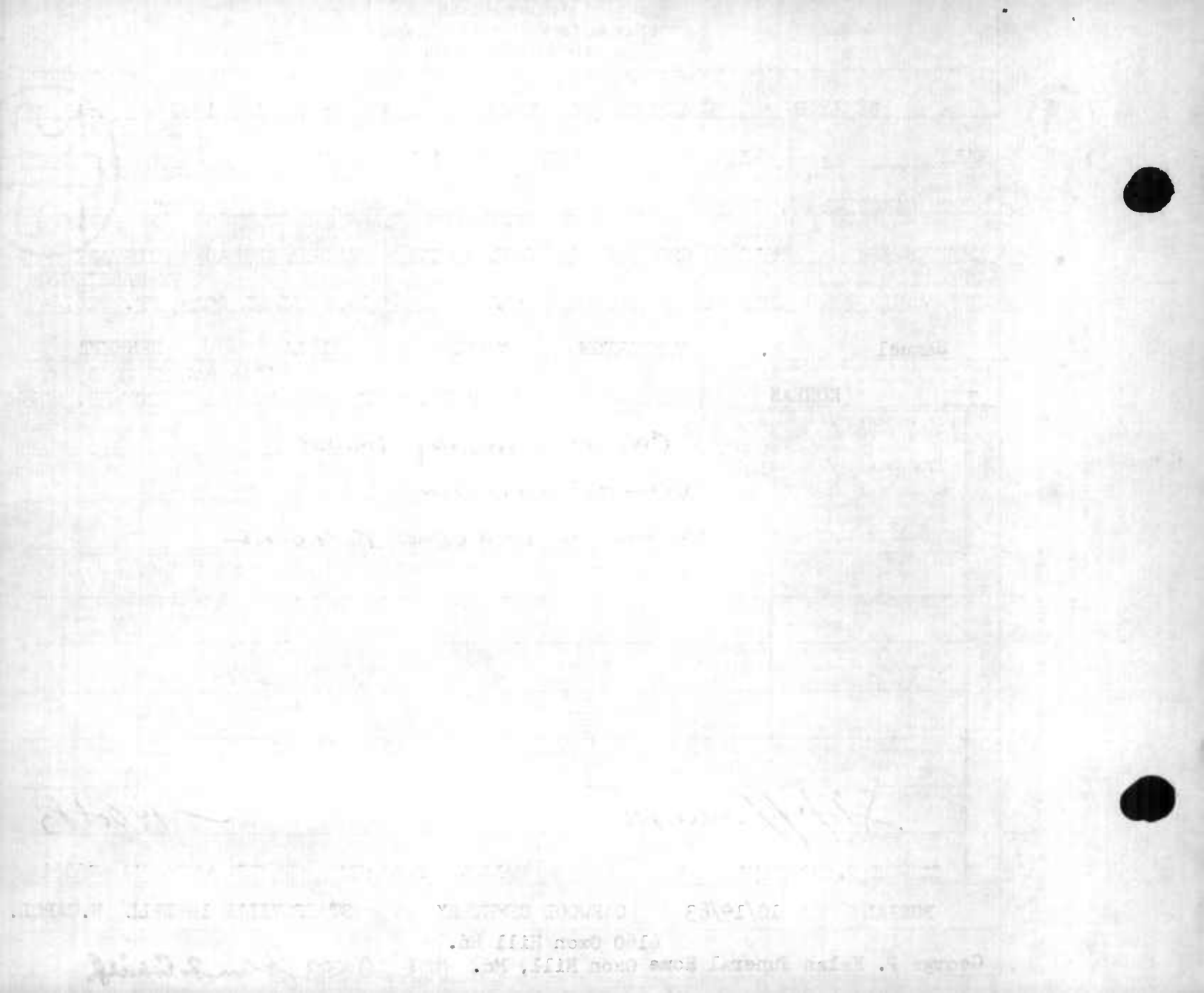
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH DAY YEAR			2b. HOUR		
BENJAMIN FRANKLIN TEMPLETON			OCTOBER 14 1983			8:17 P.M.					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		
MALE			WHITE			JULY 11 1930			53 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
NORTH CAROLINA			UNITED STATES						PRINCE GEORGE'S COUNTY MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING 1 YEAR)			12b. KIND OF BUSINESS OR INDUSTRY		
ANDREWS AFB			MALCOLM GROW USAF MEDICAL CENTER			WEATHER BUREAU			MILITARY		
13a. STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?			13d. STREET ADDRESS		
FORT WASHINGTON			PRINCE GEORGE Maryland			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1326 PALMER ROAD MD. 20744		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Samuel M. TEMPLETON			MAGGIE LELA BENNETT								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
YES			KOREAN			242-36-4679			JOSEPHINE TEMPLETON 1326 PALMER ROAD FT WASHINGTON MD. 20744		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:											
4560 IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY FAILURE</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
(b) <u>VOLUME DEPLETION</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>ESOPHAGEAL VARICEAL BLEEDING</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
			HOUR A.M. MONTH DAY YEAR								
			P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1 OCT</u> , 19 <u>83</u> , to <u>14 OCT</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>14 OCT</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE			22c. DATE SIGNED		
<i>Stuart N. Hoffman</i>									14 Oct 83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
STUART N. HOFFMAN						MALCOLM GROW USAF MED CEN AAFB, MD 20331					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION		
BURIAL			10/19/83			OAKWOOD CEMETERY			STATESVILLE IREDELL N. CAROL.		
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
George P. Kalas Funeral Home Oxon Hill, Md.						OCT 20 1983			<i>John J. Connel</i>		

MEDICAL CERTIFICATION



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 8 1 3 0

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ERNEST TERRELL V			2a. DATE OF DEATH MONTH DAY YEAR 10 19 83			2b. HOUR 10:24A.M.				
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR April 7 1935		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 10 19		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.				
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Equip. Operator		12b. KIND OF BUSINESS OR INDUSTRY Covt.		
13a. STATE D.C.		13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1754 Seatons Pl N.W.		
14. FATHER'S NAME FIRST MIDDLE LAST Joe N. Terrell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elberta Trice						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 240-48-4571		17. INFORMANT Rhonda L. Terrell (Daughter)				ADDRESS 4130 24th Avenue Temple Hill Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Failure 0389 DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS, CHF, Resp. failure. DUE TO, OR AS A CONSEQUENCE OF (c) Septic Arthritis, Coagulopathy APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) 4 tube (Thrombocytopeny), knee (operation) & Tracheostomy										
19a. DATE OF OPERATION 10/19/83			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 9/24 , 19 83 , to 10/19 , 19 83 , that (I) (we) last saw the deceased alive on 10/19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE E. S. COLOVER			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/19/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. S. COLOVER			22e. ADDRESS 7501 SUPPACHTS Rd, Clinton, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct/25/1983		23c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, PO, Maryland			
24. FUNERAL DIRECTOR NAME G. M. Harton			ADDRESS 400 Kennedy ST NW			DATE RECEIVED BY REGISTRAR 10/21/83			REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

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20% COLIC

20% COLIC

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. IF YOU ARE THE FUNERAL DIRECTOR, PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) LESLIE THIGPEN										2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input checked="" type="checkbox"/> 10/16 1983	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 6 1912		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD 10 16 1983	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH P.G. County	
10. CITY OR TOWN OF DEATH Temple Hills				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3304 Curtis Drive, Apt. 303				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY P.G. County		13c. CITY OR TOWN Temple Hills		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS 3304 Curtis Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown				16. ADDRESS Forestville Md.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. Unknown				17. INFORMANT William Thigpen			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4029 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Hypertensive Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. '19'				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Augusto P. Rodriguez						TITLE (SPECIFY) Deputy		DATE SIGNED 10/16/1983		MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.						ADDRESS 5009 Rayburn Ct., Temple Hills, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10/20/83		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland	
24. FUNERAL DIRECTOR NAME Johnson & Jenkins Inc.						25a. DATE REC'D. BY REGISTRAR Oct 25 1983		25b. REGISTRAR'S SIGNATURE John E. Smith			

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1941

Non-Resident

THE ...

Lincoln ...

...

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR Item 18a 2-7-84 cn STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) EARL RICHARD THOMAS					2a. DATE OF DEATH MONTH 10 DAY 14 YEAR 83			2b. HOUR 9:30P M	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH JULY DAY 19 YEAR 1933		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.		IF UNDER 1 YEAR MONTHS DAYS 	
7a. BIRTHPLACE (COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.			
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FOREMAN		12b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT	
13a. STATE MARYLAND		13b. COUNTY CHARLES		13c. CITY OR TOWN MASON SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS ROUTE 225 MASON SPRINGS, MARYLAND 20640	
14. FATHER'S NAME FIRST ALLISON W. MIDDLE THOMAS LAST 					15. MOTHER'S MAIDEN NAME FIRST MARGARET MIDDLE E. LAST SIMMS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. KOREAN CON. 220-28-6549		17. INFORMANT SHIRLEY M. THOMAS LA PLATA, MARYLAND 20646					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). Gran Negative Bacteria									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia Thrombocytopenia									
2028 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Respiratory arrest									
DUE TO, OR AS A CONSEQUENCE OF (c) Lymphoma under Chemotherapy									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/11 , 19 83 , to 10/14 , 19 83 , that (I) (we) last saw the deceased alive on 10/14 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature] DEGREE M.D.						22c. DATE SIGNED 10/14/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 18, 1983		23c. NAME OF CEMETERY OR CREMATORY Metro. Un. Meth. Ch.		23d. LOCATION CITY OR TOWN COUNTY STATE Pomonkey, Charles Md.		
24. FUNERAL DIRECTOR NAME THORNTON'S FUNERAL HOME						25a. DATE REC'D. BY REGISTRAR OCT. 19 1983			
ADDRESS POMONKEY, MARYLAND						25b. REGISTRAR'S SIGNATURE [Signature]			



3-20-1941
Institution of ...
COLL

COLL
10-11-1941
...

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, IT SHOULD BE EXECUTED AS SOON AS POSSIBLE. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PW 3, RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ERNESTINE MURRY THOMAS							2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> OCT 17 1983		2b. HOUR 9:39 AM		
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR SEP 3, 1921	6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD OCT 17, 1983		2d. HOUR 9:39 AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD					
10. CITY OR TOWN OF DEATH ANDREWS AFB		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW USAF MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC WORK		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE WASHINGTON		13b. COUNTY D.C.		13c. CITY OR TOWN HILLCREST HTS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4633 HILLSIDE ROAD, S.W.			
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE GABLE THOMAS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSETTA BROWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-34-7374		17. INFORMANT ADDRESS ANNA M. THOMAS 5061 F STREET, WASHINGTON, D.C.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: CARDIAC ARREST 4292 IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Patent plastic coronary artery disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Augusto P. Rodriguez			TITLE (SPECIFY) Deputy		M.D. _____		MEDICAL EXAMINER		DATE SIGNED 10-17-83		
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.			ADDRESS 5009 Rayburn Ct., Temple Hills, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE OCT 22, 1983		23c. NAME OF CEMETERY OR CREMATORY HARMONY MEMORIAL		23d. LOCATION CITY OR TOWN COUNTY STATE LANDOVER, MD				
24. FUNERAL DIRECTOR NAME ALEXANDER S. POPE			ADDRESS 2617 PENNSYLVANIA AVE S.E.			24a. DATE REC'D. BY REGISTRAR OCT 25 1983		24b. REGISTRAR'S SIGNATURE John J. L... ..			



DOMESTIC WORK

RECEIVED

LA. ROYAL, MI

OCT 22, 1963 HAZARD MEMORIAL

UNIT 1

LA. ROAD 2. POLE 711 PENNSYLVANIA AVE S.E.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) DANIEL H. THOMPSON										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 10 7 19 83	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH 2 DAY 17 YEAR 24	6. AGE (IN YEARS) (LAST BIRTHDAY) 59 YRS.	7. IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN. 0	8. IF UNDER 24 HRS. MONTHS 0 DAYS 0 HOURS 0 MIN. 0	2c. DATE PRONOUNCED DEAD 10 7 19 83		2d. HOUR 7:30 AM			
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.					
10. CITY OR TOWN OF DEATH Oxon Hill		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1202 Birchwood Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Military			
13a. STATE Delaware		13b. COUNTY Kent		13c. CITY OR TOWN Dover		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1152 Charles Dr. 99999			
14. FATHER'S NAME FIRST Evan MIDDLE B. LAST Thompson			15. MOTHER'S MAIDEN NAME FIRST Irena MIDDLE Chandler			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes 16a. SOCIAL SECURITY NO. 1942-1966 16b. SOCIAL SECURITY NO. 227-22-6213					
17. INFORMANT ADDRESS Florence L. Thompson same as item 13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Augusto P. Rodriguez		TITLE (SPECIFY) Deputy		MEDICAL EXAMINER		DATE SIGNED 10/7/1983					
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct., Temple Hills, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/10/83		23c. NAME OF CEMETERY OR CREMATORY Sharon Hill Cemetery		23d. LOCATION CITY OR TOWN Dover COUNTY STATE Del.					
24. FUNERAL DIRECTOR NAME G.P. Kalas ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.				25a. DATE REG'D. BY REGISTRAR OCT 10 1983		25b. REGISTRAR'S SIGNATURE John J. Smith					

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

TO : SAC, NEW YORK
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]
DATE: [Illegible]
[Illegible text block containing various details and references]

ATTENTION: [Illegible]

[Large handwritten signature and stamp area]
[Illegible text and markings at the bottom of the page]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Edward		MIDDLE F.		LAST Thompson		2a. DATE KNOWN OF DEATH		ESTIMATED 10-8 1983		2b. HOUR 905 PM	
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 4 14 19		6. AGE [IN YEARS (LAST BIRTHDAY)] 64 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD 10-8 1983		2d. HOUR 905 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.							
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DRS' Hosp. of P. & Co.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Cable Splicer				12b. KIND OF BUSINESS OR INDUSTRY Co. Telephone			
13a. STATE Md		13b. COUNTY PG		13c. CITY OR TOWN Oxon Hill		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3407 Lumar Drive 20745					
14. FATHER'S NAME FIRST MIDDLE LAST George W. Thompson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Quigley									
16a. WAS DECEASED EVER (YES, NO, OR UNKNOWN) yes		IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) WWII		16b. SOCIAL SECURITY NO. 577-12-0010		17. INFORMANT ADDRESS Polly Thompson same as item 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of colon</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost (b) <u>metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 1a.													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>Said A. Daee</u>				TITLE (SPECIFY) M.D. <u>Deputy</u>				MEDICAL EXAMINER				DATE SIGNED 10-10-83	
EXAMINER'S NAME (TYPE OR PRINT) <u>Said A. Daee, M.D.</u>				ADDRESS <u>5632 Annapolis Rd. #10</u>									
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 10/11/83		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cemetery				23d. LOCATION CITY OR TOWN Cheltenham		COUNTY P.G.		STATE Md.	
24. FUNERAL DIRECTOR NAME ADDRESS G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.													

OCT 15 1983

REGISTRAR SIGNATURE

RECEIVED
U.S. DEPARTMENT OF THE ARMY
WASHINGTON, D.C.

24-10-1947

10-10-1947

RECEIVED
U.S. DEPARTMENT OF THE ARMY
WASHINGTON, D.C.

10-10-1947

10-10-1947

10-10-1947

RECEIVED
U.S. DEPARTMENT OF THE ARMY
WASHINGTON, D.C.

10-10-1947



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in order to perform an autopsy.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) HELEN Louise TOWNSHEND					2a. DATE OF DEATH MONTH 10 DAY 6 YEAR 83 2b. HOUR 4.55 ^{PM}				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 6 DAY 24 YEAR 1905		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.			
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinton Community Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Public Sch.	
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Brandywine		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 15915 Bald Eagle School Road 20613	
14. FATHER'S NAME FIRST Norvall MIDDLE LAST Hyde				15. MOTHER'S MAIDEN NAME FIRST Rhoda MIDDLE LAST Canter					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 213-38-1673		17. INFORMANT ADDRESS Robert W. Townshend same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest, Respiratory failure 5789 DUE TO, OR AS A CONSEQUENCE OF* (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Gastrointestinal Bleeding Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Acute Urinary tract infection, Cardiac arrhythmia									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Sept 21 19 83 , to Oct. 6 19 83 , that (I) (we) last saw the deceased alive on Oct 5 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Grig Dwidjar M.D.						DEGREE		22c. DATE SIGNED 10-6-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EYRWS DWIDJAR M.D.						22e. ADDRESS 6188 OKON HILL RD, OKON HILL, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-10-83		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cem.		23d. LOCATION CITY OR TOWN Baden, P.G. COUNTY Maryland STATE		
24. FUNERAL DIRECTOR NAME Hunt Funeral Home, Waldorf, Md. ADDRESS						25. DATE REC'D. BY REGISTRAR OCT 11 1983		26. REGISTRAR'S SIGNATURE John J. Connel	

BP

10-10-55

Western Union

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IRENE K. TRAVASCIO					2a. DATE OF DEATH MONTH DAY YEAR OCT-24-1983			2b. HOUR 4.05P.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 3, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.				
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY -		
13a. STATE Md.					13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Mt. Rainier		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Detwiler					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Kreppel					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-03-7881		17. INFORMANT A Edward W. Simons			ADDRESS Same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Vulva - Metastases 1844 DUE TO, OR AS A CONSEQUENCE OF (b) A-S. H. D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 19 76 , to 10-24 , 19 83 , that (I) (we) lost saw the deceased on 10-24 , 19 83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE SURESH GUPTA					DEGREE MD			22c. DATE SIGNED 10-25-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SURESH GUPTA M.D.					22e. ADDRESS 3503 PERRY ST. MT RAINIER, MD. 20822					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 10-27-83		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.			
24. FUNERAL DIRECTOR NAME Nailey's F.H. Inc. Mt. Rainier, Md.					25a. DATE REC'D. BY REGISTRAR OCT 31 1983		25b. REGISTRAR'S SIGNATURE [Signature]			

BP

4.059.01

OCT-11-1957

TRAVASCO

IRINE

PRINCE GEORGE'S COUNTY

PRINCE GEORGE'S GENERAL HOSPITAL

COVENTRY

Geo. J. Smith

Geo. J. Smith

11-11-1957

Princess Anne
County, Md.

3502 PERRY ST. MT BALTIMER, MD. 20832

SURESH GUPTA M.D.

Gravestone W-27-22 44. Lincoln Cemetery, Greenwood, F. Geo. Md.

W-27-22 44. Lincoln Cemetery, Greenwood, F. Geo. Md.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1. FOR STATE REGISTRAR										2. DATE KNOWN OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Donald P. Truesdell										2. DATE KNOWN OF DEATH MONTH DAY YEAR 10 18 1983			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 27, 1931		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 52		7. IF UNDER 1 YR. MONTHS DAYS		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 18 1983			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.		2d. HOUR 6:37 P.M.					
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Geologist		12b. KIND OF BUSINESS OR INDUSTRY Interior					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Maryland		13b. COUNTY P.G. Co.		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8707 Granite La. 20708					
14. FATHER'S NAME FIRST MIDDLE LAST Phillip Browne Truesdell						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Price							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) Korean		16b. SOCIAL SECURITY NO. 390-28-0671		17. INFORMANT ADDRESS Charmane W. Truesdell same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cranio-cerebral Injury</u> 8120 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			
20. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 20a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 20b. TIME OF INJURY HOUR XXXX MONTH DAY YEAR 5:00 P.M. 10 18 1983 20c. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road 20d. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver in auto/auto and fixed object impact										20. AUTOPSY? (head only) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>Dennis F. Smyth M.D.</u> TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 10-19-83													
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn Street													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10/20/83		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia							
24. FUNERAL DIRECTOR FLECK FUNERAL HOME INC. 7601 Sandy Spring Rd. Laurel, Md. 20707										25a. DATE REC'D. BY REGISTRAR OCT 24 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Smith</u>	

THE UNIVERSITY OF CHICAGO
LIBRARY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Albertine Turner			2a. DATE OF DEATH MONTH DAY YEAR October 13th. 1983		2b. HOUR 1105p	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2-10-1988		
6. AGE (IN YEARS LAST BIRTHDAY) 95		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD		
10. CITY OR TOWN OF DEATH Forestville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE IN SUCH FACILITY, THIS STREET ADDRESS) Regency Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Examiner - Ret.		
12b. KIND OF BUSINESS OR INDUSTRY Bureau Engrav.		13. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13a. STREET ADDRESS 2205 Iverson Street		
13b. STATE Maryland		13c. CITY OR TOWN Temple Hills		13d. STREET ADDRESS 20748		
14. FATHER'S NAME FIRST MIDDLE LAST Ludwig Erdman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE Bozina Bramel		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		
16b. SOCIAL SECURITY NO. 577-10-3822		17. INFORMANT Bernard A. Turner		ADDRESS As in Item 13a		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4280 Congestive heart failure + Regurg DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) infection DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: diabetes mellitus						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22a. CERTIFY THAT (I) (this hospital) attended the deceased from 8-15 , 19 83 , to 10-13 , 19 83 , that (I) (we) lost saw the deceased alive on 10-13 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		
22b. SIGNATURE William Kent Junt		DEGREE MD		22c. DATE SIGNED 10-14-1983		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William K. Furst		22e. ADDRESS 9401 Indian Head Highway		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-17-1983		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cem.		
23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.		24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home		25a. DATE REC'D. BY REGISTRAR Oct 18 1983		
25b. REGISTRAR'S SIGNATURE John J. Carroll		25c. ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.		25d. ADDRESS		

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James M. Smith

10-1-51

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Elizabeth TUTT			2a. DATE OF DEATH MONTH DAY YEAR 10/16/83		2b. HOUR 1143 P M
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 7 7 03		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.	
10. CITY OR TOWN OF DEATH HYATTSVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL MANOR		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD			13b. COUNTY Mont.	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST JOHN DELANEY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ANQUIER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None		16b. SOCIAL SECURITY NO. 213-74-0030		17. INFORMANT ADDRESS Homer Tutt, Jr. (Son) Same as #13E	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4049 IMMEDIATE CAUSE (a) GANGLERENE LEFT LIMB DUE TO, OR AS A CONSEQUENCE OF (b) ART. SC / CAR REN VAS DI'S DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS YEARS
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

DIABETES METABETIS

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/31/81 to 10/16/83, that (I) (we) last saw the deceased alive on 10/16/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE Frederick W. Schneider MD	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 10/16/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FREDERICK W. SCHNEIDER MD		22e. ADDRESS 201-8 STANF DC 20002	

23a. BURIAL, CREMATION, REMOVAL (SPECIAL) Burial	23b. DATE 10/19/83	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	23d. LOCATION CITY OR TOWN COUNTY STATE S.S. Mont. Maryland
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home 11800 New Hampshire Ave. S.S. Md.			25a. DATE REC'D. BY REGISTRAR OCT 18 1983

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		10 11 83		12:05AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		Black		MONTH DAY YEAR Jan 29 13		70 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
S. C.		USA				PRINCE GEORGE COUNTY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CHEVERLY		PRINCE GEORGE GENERAL HOSPITAL		Retired		None	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
D. C.				Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Amzie		Rena		No		076-10-5260	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Renal Failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>12 hrs</u> <u>1 yr</u>	
Mrs. Anna Reed/sister/3725 Macomb St. N.W.		3725 Macomb St. N.W. #401					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (i) (the hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (ii) (we) lost saw the deceased on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (ii) (we) told a doctor viewing the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				10/11/83	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		10-15-83		Lincoln Memorial		Suitland, Md.	
24. FUNERAL DIRECTOR				25a. DATE RECD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME John T. Rhines Co., 3015 12th St. N.E. D.C.				OCT 13 1983		John J. Conish	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Minnie Belle Uhas						2a. DATE KNOWN OF DEATH ESTIMATED 10 12 83		2b. HOUR 8:40			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March/18/1929		6. AGE (IN YEARS) LAST BIRTHDAY 54 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 12 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD	
10. CITY OR TOWN OF DEATH Hyattsville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2400 Queens Chapel Rd. #202				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookbinder		12b. KIND OF BUSINESS OR INDUSTRY Bookbinding	
13a. STATE Maryland				13b. COUNTY P.G. Co.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS #202 2400 Queens Chapel Rd	
14. FATHER'S NAME FIRST MIDDLE LAST Fletcher - Huffman						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lura E. Mc Dowell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 232-40-2688		17. INFORMANT ADDRESS Stephen Uhas/3531 Madison Pl. Hyattsville, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3030 Congestive heart failure Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. Alcoholism (b) hypertension (c) hypertension										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Sgt A-J DARRIN				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER		DATE SIGNED 10-12-83	
EXAMINER'S NAME (TYPE OR PRINT) 5632 annapolis Rd				ADDRESS Bladensburg MD 20710							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Oct/17/83		23c. NAME OF CEMETERY OR CREMATORY Maryland National Mem. Park Laurel, P.G.Co., Maryland				23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Chambers Funeral Home						ADDRESS Riverdale, Maryland		25a. DATE REC'D. BY REGISTRAR OCT 19 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST Helen MIDDLE M. LAST Violette										2a. DATE KNOWN OF DEATH MATED	
3. SEX Female 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR July 6, 1915 6. AGE (IN YEARS) LAST BIRTHDAY 68 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN 8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN										2b. DATE KNOWN OF DEATH MATED 10 2 83 19 2d. HOUR 5.04 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.	
10. CITY OR TOWN OF DEATH Riverdale 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker 12b. KIND OF BUSINESS OR INDUSTRY Home											
13a. STATE Maryland 13b. COUNTY P.G. Co. 13c. CITY OR TOWN Brentwood 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 3711 Varnum Street (20722)											
14. FATHER'S NAME FIRST William MIDDLE A. LAST Krug 15. MOTHER'S MAIDEN NAME FIRST Viola MIDDLE - LAST Hughes											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 16b. SOCIAL SECURITY NO. None 579-16-2419 17. INFORMANT ADDRESS Louis R. Violette/3711 Varnum St. Maryland Brentwood											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) myocardial infarction Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) hypertension (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE SAIDA A. DARR MY TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER DATE SIGNED 10-2-83											
EXAMINER'S NAME (TYPE OR PRINT) 5632 annapolis Rd. Address Bladysing MD 20710											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE Oct/6/83 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G. Co., Maryland											
24. FUNERAL DIRECTOR NAME Chambers Funeral Home Address Riverdale, Maryland 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE											

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 8 1 4 4

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JUNE ROTERT WAELCHLI			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 20, 1983		2b. HOUR 8:40 a.m.						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 31 1907		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.					
10. CITY OR TOWN OF DEATH LANHAM		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS' HOSPITAL of P.G. CO.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Maryland		13b. COUNTY Pr Geo		13c. CITY OR TOWN Upper Marl		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12200 Blaketone Street 20332			
14. FATHER'S NAME FIRST MIDDLE LAST Unknown Rotert				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 200 30 3839		17. INFORMANT Fred Waelchli		ADDRESS Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 4850 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) bronchopneumonia and pulmonary abscess, extensive DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from 7/25 , 19 83 , to 10/20 , 19 83 , that (I) (we) last saw the deceased alive on 10/19 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22b. SIGNATURE Barry Rosenberg		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10/21/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry Rosenberg, M.D.				22e. ADDRESS 6501 Landover Rd., Cheverly, Md. 20785							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 23Oct1983		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY Suitland Maryland					
24. FUNERAL DIRECTOR NAME Robert E Wilhelm				ADDRESS Funeral Home Suitland Maryland				25a. DATE REC'D. BY REGISTRAR OCT 28 1983		25b. REGISTRAR'S SIGNATURE John J. Coker	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked on item 1B shows any injury, or other traumatic event, the medical examiner may be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLOTTE E. WALKER			2a. DATE OF DEATH MONTH DAY YEAR 10. 31. 83		2b. HOUR 4:30 AM	
3. SEX F.	4. RACE Black.	5. DATE OF BIRTH MONTH DAY YEAR 1 2 1897	6. AGE (IN YEARS LAST BIRTHDAY) 86. YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washing P.C.	7b. CITIZEN OF WHAT COUNTRY? USA.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH P.B. MD.			
10. CITY OR TOWN OF DEATH Maryland.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Adelphi Manor.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland	13b. COUNTY P.G.	13c. CITY OR TOWN CAPITOL HGTS.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 409 EASTERN AVENUE, 20743		
14. FATHER'S NAME FIRST MIDDLE LAST William Sime		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JENNY Carter				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 578 01 3801B		17. INFORMANT ADDRESS Mrs. Evelyn B. Lewis-daughter-1407 Elkwood Lane #303, Capitol Hgts., Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROTIC HEART DIS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS YEARS						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CAROTIDARTERIAL DISEASE						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 1981 , to 10/31 , 19 83 , that (I) (we) last saw the deceased alive on 10/20 , 19 83 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If deceased did not view the body after death.)						
22b. SIGNATURE 		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/31/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P SCHISLER MD		22e. ADDRESS 7500 GREENWAY CTR DR GREENBELT MD 20770				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov. 4, 1983	23c. NAME OF CEMETERY OR CREMATORY Maryland National Cemetery Laurel, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR Stewart Funeral Home-4001 Benning Rd., MD						
APPROVED BY REGISTRAR 7 1983						
REGISTRAR'S SIGNATURE 						

BP



100% COTTON

CLARK'S



MADE IN U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST VIRGINIA WALLACE				10 27 83			
2b. HOUR 5:00AM							
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR Aug. 29-1929		6. AGE (IN YEARS LAST BIRTHDAY) 46	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY P.G.		13c. CITY OR TOWN Forestville	
14. FATHER'S NAME FIRST MIDDLE LAST John T. Warner				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-32-3513		17. INFORMANT Wilton Wallace-Husband		ADDRESS S.S.A.A	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Advanced Metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10-17, 19 83, to 10-27, 19 83, that (I) (we) last saw the deceased alive on 10-27-83, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE SAID A. DAE M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/28/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAID DAE, M.D.		22e. ADDRESS 5632 ANNAPOLIS RD. BLADENSBURG, MD					
23a. (BURIAL) CREMATION, REMOVAL (SPECIFY)		23b. DATE 11/1/1983		23c. NAME OF CEMETERY OR CREMATORY Md. Vet. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Md.	
24. FUNERAL DIRECTOR NAME Martell Adams		ADDRESS Aguasco Md.		25a. DATE REC'D. BY REGISTRAR NOV 9 1983		25b. REGISTRAR'S SIGNATURE Joan J. Conner	

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WALLACE

VIRGINIA

PRINCE GEORGES

PRINCE GEORGES GENERAL HOSPITAL

CHEVERLY



2022 ANNAPOLIS RD. ANNAPOLIS, MD

SAID DATE, M.G.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Mary A. Ward			2a. DATE OF DEATH MONTH DAY YEAR October 27, 1983		2b. HOUR 10:58A
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 18, 1901	6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD		
10. CITY OR TOWN OF DEATH Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY P.G. Co.	13c. CITY OR TOWN Lanham	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 6941 Heidelberg Rd. 20706
14. FATHER'S NAME FIRST MIDDLE LAST Simon Slymcock			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maryann Gaciek		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 208-16-7473	17. INFORMANT ADDRESS Irene W. Eanes 502 7th St. Laurel, Md. 20707		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4/100

DUE TO, OR AS A CONSEQUENCE OF

(b) ASD

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

4 hrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6-1, 1980, to 10-27, 1983, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.			
22b. SIGNATURE Bruce E. Dunn	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 27 Oct 83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE DUNN	22e. ADDRESS 5711 SARVIS DIVERDALE		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/31/83	23c. NAME OF CEMETERY OR CREMATORY Md. National Mem. Parl	23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, P.G. Co. Md.
24. FUNERAL DIRECTOR FLECK FUNERAL HOME, INC. 7601 Sandy Spring Rd. Laurel, Md. 20707		25a. DATE REC'D. BY REGISTRAR OCT 28 1983	25b. REGISTRAR'S SIGNATURE John G. Canick

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. IF YOU ARE A FUNERAL DIRECTOR, PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

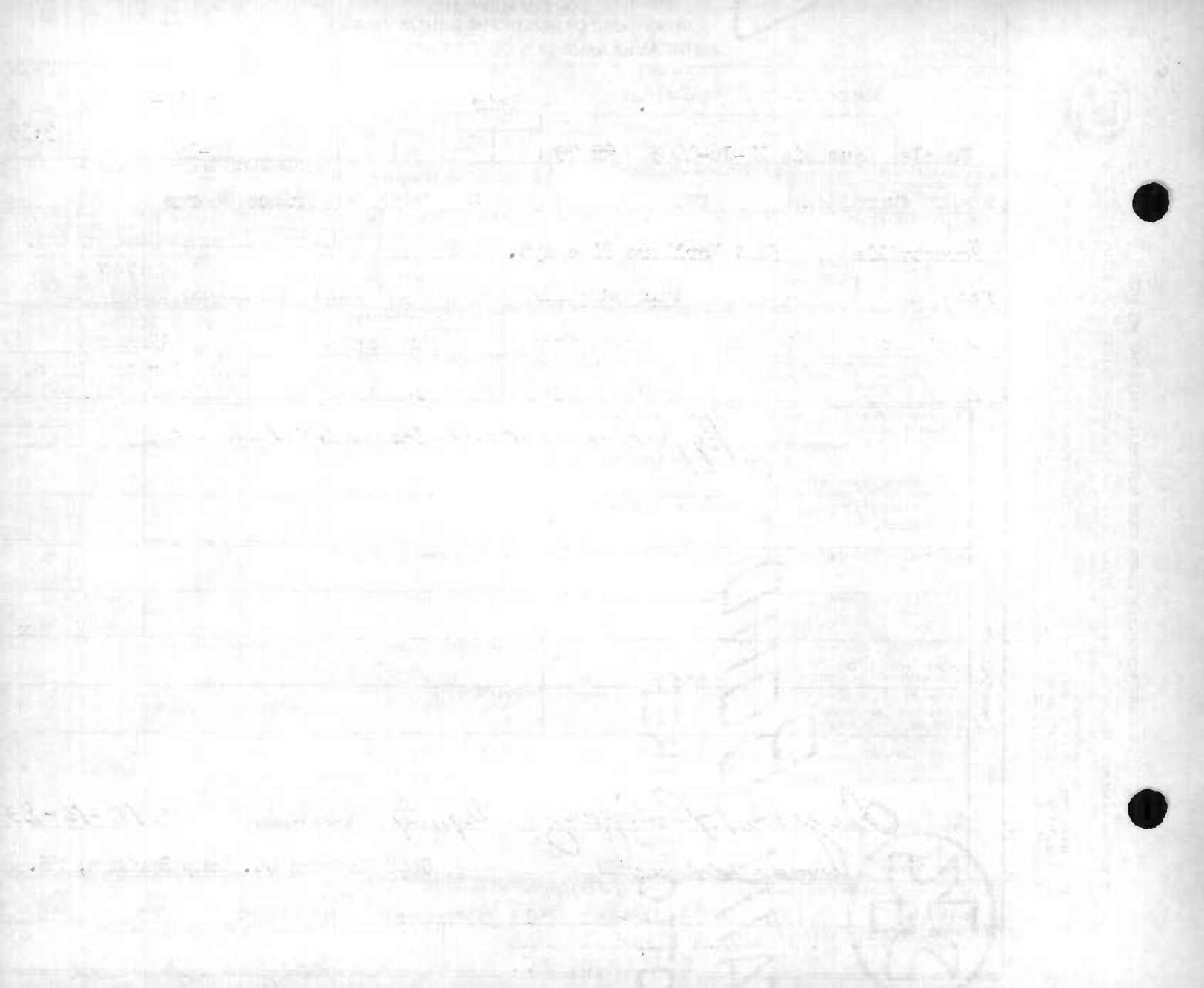
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DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Margaret		MIDDLE Julia		LAST Weir		7a. DATE KNOWN OF DEATH ESTIMATED 10-15 1983		7b. HOUR M P	
3. SEX Female	4. RACE Caucasia	5. DATE OF BIRTH MONTH DAY YEAR 12-16-1903		6. AGE (IN YEARS) (LAST BIRTHDAY) 82 79S.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 10-15 19 83		7d. HOUR M P 3:35	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD					
10. CITY OR TOWN OF DEATH Forestville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5821 Marlboro Pike Apt. #202						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Clerk		12b. KIND OF BUSINESS OR INDUSTRY Hecht Co.	
13a. STATE Maryland		13b. COUNTY PG		13c. CITY OR TOWN Forestville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 20747 5821 Marlboro Pike #202			
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Wolfe Browning				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Ulmer				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16a. SOCIAL SECURITY NO. 578-40-9905				17. INFORMANT Jean Linkins				ADDRESS 6309 Armor Drive Clinton, Md. 20735			
18. CAUSE OF DEATH (Enter only one cause pending for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4029 IMMEDIATE CAUSE (a) <i>My part in the car accident</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Augusto Rodriguez</i>				TITLE (SPECIFY) M.D. <i>Deputy</i>				MEDICAL EXAMINER DATE SIGNED 10-16-83			
EXAMINER'S NAME (TYPE OR PRINT) Augusto Rodriguez MD				ADDRESS 5009 Rayburn Ct. Camp Springs, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-18-83		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md			
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm				Funeral Home Suitland, Md.				25a. DATE REC'D. BY REGISTRAR OCT 24 1983			
								25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Page 4 should be retained by the funeral director 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 1.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Pearl L. Wells				Oct. 8 1983 720a			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 - 26 - 1900		6. AGE (IN YEARS LAST BIRTHDAY) 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.	
10. CITY OR TOWN OF DEATH Oxon Hill		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fort Washington Rehab. Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY none	
13a. STATE Maryland		13b. COUNTY P.G.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13. STREET ADDRESS 13308 Cleveland Lane 20744	
14. FATHER'S NAME FIRST MIDDLE LAST George Schabacker		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna M. Lutz		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 191-226-6412		17. INFORMANT ADDRESS Elizabeth A. Wells As in item 13a					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Necrotizing Metastatic Squamous Cell Ca. 2041				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Stage III Chronic Lymphocytic Leukemia							
(c) DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 10/4/83 to Oct. 8, 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Irwin H. Ruback		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/8/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) IRWIN H. RUBACK, M.D.		22e. ADDRESS 10905 FT. WASHINGTON RD. FT. WASHINGTON, MD. 20744					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10-9-1983		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Maryland	
24. FUNERAL DIRECTOR George P. Kalas Funeral Home				25a. DATE RECEIVED BY REGISTRAR 10/13/83			
NAME 6160 Oxon Hill Rd. Oxon Hill, Maryland				25b. REGISTRAR'S SIGNATURE John J. Canale			

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 8 1 5 0

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GERTRUDE Catherine WHIPPLE			2a. DATE OF DEATH MONTH DAY YEAR 10 05 83		2b. HOUR 1:00PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR February 28, 1914	6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.			
10. CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk Sears Robuck and Co.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.,		13b. CITY OR TOWN Charles Waldorf	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 4510 Orleans Lane 20601		
14. FATHER'S NAME FIRST MIDDLE LAST John McCabe			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Sears			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-01-3505		17. INFORMANT ADDRESS Aleica Downs Same as #13		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: 5939 IMMEDIATE CAUSE (a) Cerebral Vascular Accident		
DUE TO, OR AS A CONSEQUENCE OF (b) Septicemia from Urinary Tract Infection		
DUE TO, OR AS A CONSEQUENCE OF (c) Renal Infection		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Coronary Artery Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from **5/22**, 19 **83**, to **10/5**, 19 **85**, that (I) (we) last
saw the deceased alive on **10/5**, 19 **83**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE G. R. R. H. WATKINS	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 10/5/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. R. R. H. WATKINS		22e. ADDRESS Waldorf, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/8/83	23c. NAME OF CEMETERY OR CREMATORY St. Agnes Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Forrest City Pa. Susquehanna Co.
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24. FUNERAL DIRECTOR NAME Lee Funeral Home Inc.	25a. DATE REC'D. BY REGISTRAR 10/25/83	25b. REGISTRAR'S SIGNATURE John J. Carish
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



10/2/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

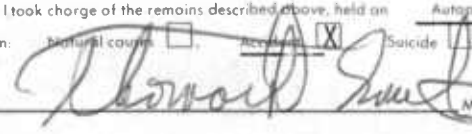

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) KEITH E WILKERSON					2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 16, 1983				2b. HOUR 0657a M		
3. SEX MALE		4. RACE CAUCASION		5. DATE OF BIRTH MONTH DAY YEAR JUNE 25 83		6. AGE (IN YEARS LAST BIRTHDAY) 3½ MONTHS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.					
10. CITY OR TOWN OF DEATH ANDREWS AFB		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A			
13a. STATE FLORIDA		13b. COUNTY Alachua		13c. CITY OR TOWN HAWTHORNE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS RT 2 BOX 25 HAWTHORNE, FLA			
14. FATHER'S NAME (TYPE OR PRINT) NEAL E. WILKERSON				15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) MARGARET Rains							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS RT 2 BOX 25 MARGARET WILKERSON HAWTHORNE, FLA 32640					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 7599 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) MULTIPLE CONGENITAL DEFECTS DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 14 OCT , 19 83 , to 16 OCT , 19 83 , that (I) (we) lost saw the deceased alive on 16 OCT , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE D. Harnisch, MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 16 OCT 83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID R HARNISCH						22e. ADDRESS Malcolm Grow Medical Center					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 21, 1983		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Gainsville Alachua Florida			
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Maryland						25a. DATE REC'D. BY REGISTRAR OCT 20 1983			25b. REGISTRAR'S SIGNATURE		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHAM - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Charles L. Willis										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 10/21/83			
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR NOV 2, 1942		6. AGE (IN YEARS) (LAST BIRTHDAY) 40 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD 10/21/83			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA				7b. CITIZEN OF WHAT COUNTRY? UNITED STATES				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.			
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CORRECTION OFFICER		12b. KIND OF BUSINESS OR INDUSTRY D.C.GOV'T.			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE MARYLAND		13b. COUNTY PRINCE GEORGE		13c. CITY OR TOWN CLINTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12809 Apple Cross Drive					
14. FATHER'S NAME FIRST MIDDLE LAST FRANK				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DOROTHY CALHOUN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 577 56 2733		17. INFORMANT son				ADDRESS Robert Jennifer - 12809 Applecross Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries 8120 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:25 P.M. 10/20/83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject driver in auto/auto collision							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) highway		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 9200 Pascataway Rd., Clinton, P.G., Md.							
22a. I certify that I took charge of the remains described above, held on death resulted from: <input type="checkbox"/> natural cause <input checked="" type="checkbox"/> Accidents <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion													
ACTUAL SIGNATURE 				TITLE (SPECIFY) Deputy Chief				MEDICAL EXAMINER				DATE SIGNED 10/21/83	
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10/26/83		23c. NAME OF CEMETERY OR CREMATORY Washington National Cem. Suitland				23d. LOCATION CITY OR TOWN COUNTY STATE PG Maryland			
24. FUNERAL DIRECTOR NAME ALEXANDER S. POPE				ADDRESS 2617 Pennsylvania Ave., S.E. DC				25a. DATE REC'D. BY REGISTRAR OCT 28 1983				25b. REGISTRAR'S SIGNATURE 	

NAME BLACK NOV 2 1941

PENNSYLVANIA UNITED STATES

MA YLAND PRINCE GEORGE ALBANY

THOMAS WILLIS PROPERTY CASHMERE

NOV 2 1941 - 1940 Application D.

WASHINGTON F. 1941-1940 Pennsylvania Ave., S.E. D.C.

NOV 26 1941

Washington National Jan. 1941



NOV 26 1941

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MALCOLM C. WILLIS			2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 10-1-83 19			2b. HOUR M			
3. SEX MALE	4. RACE BLK.	5. DATE OF BIRTH MONTH DAY YEAR 2-13-1955	6. AGE (IN YEARS) LAST BIRTHDAY 28 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD 10-1-83 19			2d. HOUR 4:37P
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WSSC-Md.		12b. KIND OF BUSINESS OR INDUSTRY N	
13a. STATE MD.		13b. COUNTY P.G.C.		13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1219 CHAPELWOOD LANE			
14. FATHER'S NAME FIRST MIDDLE LAST SAMMIE WILLIS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE SHARP					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 574-74-2434		17. INFORMANT ADDRESS ELIZABETH SHARP - SAME AS 13E			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY: Intravenous NarcotismAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

3049
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(a) IMMEDIATE CAUSE (a) _____
DUE TO, OR AS A CONSEQUENCE OF _____

(b) _____
DUE TO, OR AS A CONSEQUENCE OF _____

(c) _____

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.ACTUAL SIGNATURE *Dennis F. Smyth, M.D.* TITLE (SPECIFY) Assistant MEDICAL EXAMINER

DATE SIGNED 10-2-83

EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL		23b. DATE 10-6-83		23c. NAME OF CEMETERY OR CREMATORY HARMONY MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE HIGHLAND PK. MD.	
24. FUNERAL DIRECTOR NAME H.S. Washington & Son - Baltimore Ave. N.E.				25a. DATE REC'D. BY REGISTRAR OCT 4 - 1983		25b. REGISTRAR'S SIGNATURE John J. Connelley	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																			
1. FOR STATE REGISTRAR		REG. NO.				8 3 2 8 1 5 4													
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR		MIN.	
WESLEY		H.				WILSON		10		22		83		12:05AM					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS									
Male		White		August 31 1912		71		YRS		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
Maryland		USA				PRINCE GEORGE COUNTY													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
CHEVERLY		PRINCE GEORGE GENERAL HOSPITAL		Bailliff		PG Cty Court													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Maryland		Pr. George		Forestville		YES <input type="checkbox"/> NO <input type="checkbox"/>		6515 Grafton Street											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST									
Thomas		Howard		Wilson		Anna													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
Yes		WWII		218 09 0664		Flora Wilson		Same as #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
4100		Cardiogenic Shock												12 days					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		Pneumonia																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)															
		HOUR A.M. MONTH DAY YEAR																	
		P.M. 19																	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>																			
22a. I certify that (I) (this hospital) attended the deceased from		10/21		19		83		to		10/22		19		83		that (I) (we) last saw the deceased alive on			
above, (I) (we) (did not) view the body after death																			
22b. SIGNATURE		DEGREE		22c. DATE SIGNED															
David M. Goldman		M.D.		10-22-83															
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																	
David M. Goldman		6525 Belcrest Rd. Hyattsville, Md																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE							
Burial		25Oct1983		Chesterfield Cem		Centerville						Maryland							
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
NAME		ADDRESS																	
Robert E Wilhelm		Funeral Home		OCT 28 1983		John J. Carver													
Suitland		Maryland																	

BP

10 22 83 12-09AM

WILSON

M.

WESLEY

PRINCE GEORGE COUNTY

PRINCE GEORGE GENERAL HOSPITAL

CHEVERLY

DATE

2023 COLLOM





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))

20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Anna Mae Winebrenner			2a. DATE KNOWN OF DEATH MONTH 10 DAY 17 YEAR 1983		2b. HOUR 11:45 AM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH Feb. DAY 6 YEAR 1922	6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	IF UNDER 1 YR. MONTHS _____ DAYS _____	IF UNDER 24 HRS. HOURS _____ MIN _____	2c. DATE PRONOUNCED DEAD MONTH 10 DAY 17 YEAR 1983
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST Albert MIDDLE _____ LAST Dunn		15. MOTHER'S MAIDEN NAME FIRST Neva MIDDLE _____ LAST Johnson		13e. STREET ADDRESS 7006 Emerson Street 20784		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-26-8483		17. INFORMANT ADDRESS Address Same as Mr. Wayne C. Winebrenner No# 13e.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4148 Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .						
ACTUAL SIGNATURE Said A. Daee		TITLE (SPECIFY) Deputy		MEDICAL EXAMINER 5632 Annapolis Road		DATE SIGNED 10/18/83
EXAMINER'S NAME (TYPE OR PRINT) Said A. Daee, M.D.		ADDRESS Bladensburg, Maryland 20710				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 21, 1983		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood COUNTY P.G. STATE Maryland
24. FUNERAL DIRECTOR NAME F. Gasch's Sons		ADDRESS F.H. P.A. Hyattsville, Md.		25. DATE REC'D BY REGISTRAR OCT 19 1983		
		25b. REGISTRAR'S SIGNATURE <i>John J. [Signature]</i>				



Feb. 6, 1932

North Carolina H. S. S. Prince George's County

Prince George's General Hospital, Alexandria, Virginia

Virginia, I. O. Charlottesville

Albert, Tenn. Johnson

Mr. J. H. C. Winchman, No. 120, 370-10-100

3032 Gunpowder Road, Washington, D. C. 20710

Prince George's County, Virginia, Feb. 11, 1932

Medical examiner, Dr. Said A. Daee Notified

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and approved by the funeral director, who should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled in by the funeral director, who should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled in by the funeral director, who should be detached for use as the burial-transit permit.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-pen: Pages 1 and 2 should be filled in by the funeral director, who should be detached for use as the burial-transit permit.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
Emma L Winter		10 22 83		5:15PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. BALTIMORE CITY OR COUNTY OF DEATH	
Female	White	MONTH DAY YEAR	27 YRS.	Prince Georges County, MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Washington D.C.	U.S.A.		Prince Georges County, MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR CORPORATION		
Riverdale	Ieland Memorial Hospital.	Cashier	Southland Corporation		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		
Maryland	Prince Geo.	Mt. Rainier	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
Walter W. Defibaugh	Deloris A. Ballengee	16b. SOCIAL SECURITY NO. 217 66 1242			
17. INFORMANT	ADDRESS				
James A. Winter	Saem as #13 (Husband)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) 4310 Left frontal lobe + Basal ganglion hemorrhage					= 24 hours
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension likely					
DUE TO, OR AS A CONSEQUENCE OF (c) Fr					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hypertension					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
10/21/83	Intracerebral Hemorrhage	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	HOUR A.M. MONTH DAY YEAR				
	P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f. LOCATION	CITY OR TOWN COUNTY STATE		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22a. I certify that (I) (this hospital) attended the deceased from 10/21/83, 1983, to 10/22/83, 1983, that (I) (we) last saw the deceased alive on 10/21/83, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED		
Aleem A. Iqbal			10/23/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS	22f. DATE REC'D. BY REGISTRAR			
ALEEM A IQBAL	5632 ANAPOLIS RD. MEDCTR	OCT 26 1983			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	CITY OR TOWN	COUNTY STATE
Burial	10/26/83	Ft. Lincoln Cemetery	Brentwood P.G.		Maryland
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR		
Francis Gasch's Sons Funeral Home, P.A.			25b. REGISTRAR'S SIGNATURE		
Hyattsville, Maryland			John J. Chubb		

BLA DENW BUK

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 8 1 5 7

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARJORIE WOOD			2a. DATE OF DEATH MONTH DAY YEAR 10 02 83		2b. HOUR 4:15PM M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 23 1928		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.	
10. CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center		12. PLACE OF DEATH (TYPE OF WORK FOR MOST OF WORKING LIFE) AND INDUSTRY housewife N/A		
13a. STATE Maryland		13b. COUNTY AA	13c. CITY OR TOWN Frederick	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Morris		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anita Norfolk			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 218 095228		17. INFORMANT Russell Wood HOME CO #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 0389 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Stroke, DM, ABP DUE TO, OR AS A CONSEQUENCE OF (c) Sepsis, UTI					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9-15 , 19 83 , to 10-2 , 19 83 , that (I) (we) lost saw the deceased alive on 10-2 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Arslan: A-h		DEGREE M.D.		22c. DATE SIGNED 10/3/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABULHASAN U ANSARI		22e. ADDRESS 10905 FT. WASH. RD. Suite #207, FT. WASH. MD. 20744			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Oct 5, 1983	23c. NAME OF CEMETERY OR CREMATORY Frederick		23d. LOCATION CITY OR TOWN COUNTY STATE Frederick AA MD	
24. FUNERAL DIRECTOR NAME ADDRESS Navach Funeral Home Frederick		25a. DATE REC'D. BY REGISTRAR OCT 10 1983		25b. REGISTRAR'S SIGNATURE Sam J. Carver	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, there is any injury, or other traumatic event, the medical examiner must be notified at once.

BP

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]



8

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.
1. DECEASED NAME (TYPE OR PRINT) Florence Woodford										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 10 27 82
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR Aug. 6, 1929	6. AGE (IN YEARS) (LAST BIRTHDAY) 54 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 0 0 0 0	8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. 0 0 0 0	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 27 82	2d. HOUR 8:27	2e. HOUR 8:27	2f. HOUR 8:27	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.				7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County		
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville HOSpital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland										13b. COUNTY Laurel, Md.
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Saunders					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alise Wright					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no					16b. SOCIAL SECURITY NO. 577 32 9128A		16c. ADDRESS Mr. Arthur E. Saunders-brother-9907 Goodluck Road, Seabrook, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 2500 (b) Diabetes mellitus DUE TO, OR AS A CONSEQUENCE OF (c) Congestive heart failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.										
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE Sgt. A. DASH					TITLE (SPECIFY) M.D. Rep J		MEDICAL EXAMINER		DATE SIGNED 10-27-82	
EXAMINER'S NAME (TYPE OR PRINT)					ADDRESS					
23a. BURIAL, CREMATION, REMOVAL, ETC. DATE (SPECIFY) Burial Nov. 7, 1982					23b. NAME OF CEMETERY OR CREMATORY Maryland National Cemetery Laurel, Md.					23c. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR Stewart					DATE REC'D. BY REGISTRAR NOV 7 1982		25. REGISTRAR'S SIGNATURE John J. Carver			



Handwritten text, possibly a signature or initials, appearing vertically on the right side of the page. The characters are stylized and difficult to decipher.



VON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.				83 28159			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FURMAN WILLIAM WRIGHT					2a. DATE OF DEATH MONTH DAY YEAR 10-19-83			2b. HOUR 6:59PM	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR Aug 5 1897		6. AGE (IN YEARS LAST BIRTHDAY) 86		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE NAME AND FULL STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY P.G.		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 4306 R St. Cap. Hgts.			
14. FATHER'S NAME FIRST MIDDLE LAST Furman W. WRIGHT				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabella Rogers					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) No		17. INFORMANT ADDRESS William F. Wright 3508 Brightseat Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 4360 DUE TO, OR AS A CONSEQUENCE OF (b) General Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr 10 yr 10 yr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Pulmonary Obstructive Disease									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/18/83 to 10/19/83 , that (I) (we) lost saw the deceased alive on 10/18 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. Henry A. Wise Jr.					DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/19/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry A. Wise Jr.					22e. ADDRESS Lanham Md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-25-1983		23c. NAME OF CEMETERY OR CREMATORY Forest Hills		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton P.G. Md.		
24. FUNERAL DIRECTOR NAME Herry S. Washington & Sons					25a. DATE REC'D. BY REGISTRAR OCT 26 1983		25b. REGISTRAR'S SIGNATURE [Signature]		

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Herry & Washington & Sons
1935 Burrhead Ave NE.
Forest Hills
Clinton F.C. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

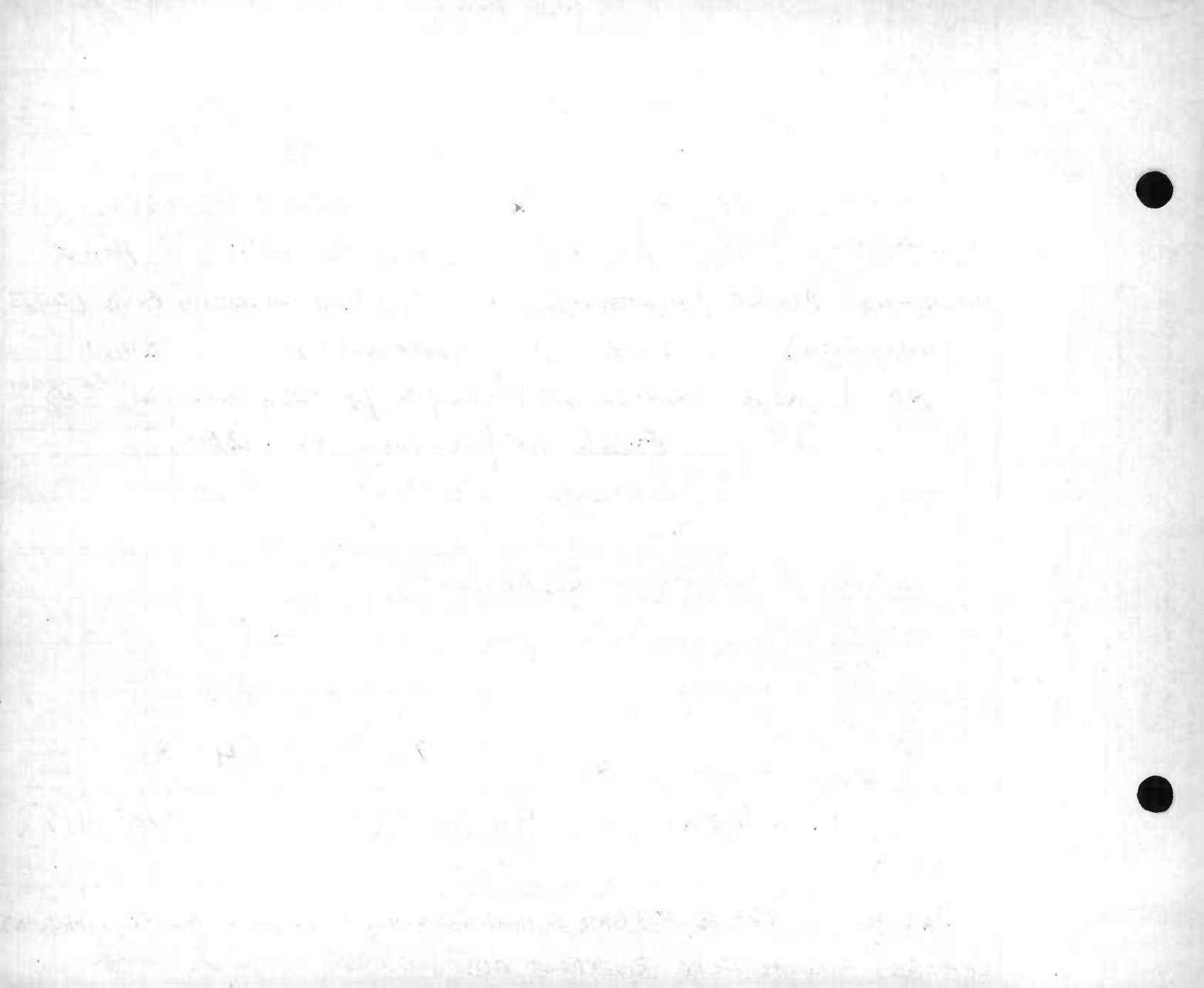
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KUM SOON YU					2a. DATE OF DEATH MONTH DAY YEAR 10 24 83			2b. HOUR 8 A.M.	
3. SEX F		4. RACE KOREAN		5. DATE OF BIRTH MONTH DAY YEAR 3 1 13		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KOREA		7b. CITIZEN OF WHAT COUNTRY? KOREA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.			
10. CITY OR TOWN OF DEATH HYATTSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MADISON MANOR NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE MARYLAND		13b. COUNTY P.G. CO.		13c. CITY OR TOWN HYATTSVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4341 UNIVERSITY BLVD. (20783)	
14. FATHER'S NAME FIRST MIDDLE LAST (UNKNOWN) LEE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (UNKNOWN) SHIM					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT STANLEY S. YU		ADDRESS 7506 GLENNON DR. BETHESDA - MD -			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Arrest</u> 3109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Cerebral infarction</u> (c) <u>organic Brain Syndrome</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) <u>Subdural hematoma status Post.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12-16</u> 19 <u>75</u> to <u>10-22</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>10-24</u> 19 <u>83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. Arora				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/24/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAKESH ARORA				22e. ADDRESS 14300 GALLANT FOX LANE Bowie					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCT. 26, 1983		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT. CO. MARYLAND		23e. DATE RECD. BY REGISTRAR 27 1983	
24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME				ADDRESS RIVERDALE, MDC		25a. DATE RECD. BY REGISTRAR 27 1983		25b. REGISTRAR'S SIGNATURE John J. Gault	

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DHMH: 16 60M 7/73

(VR A 15 (4))



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGE 1 AND 2 SHOULD BE FILED, WITHIN 1 HOUR AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28161

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Margaret Urban ZEMBOWER			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10-12-83			2b. HOUR 10:32		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 8, 1916	6. AGE (IN YEARS) (LAST BIRTHDAY) 67 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED 10-12-83	7d. HOUR 10:32	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.		
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY Prince George	13c. CITY OR TOWN Clinton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS Clinton Convalescent Center		
14. FATHER'S NAME FIRST MIDDLE LAST William J. McGreevy			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bridget Paugh			16. ADDRESS 1100 Sunburst Court Alexandria, Virginia		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-14-1167A		17. INFORMANT William J. Shuck		18. ADDRESS 4100 Sunburst Court Alexandria, Virginia		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE Intermittent Central-Cardiovascular disease with organic brain syndrome + seizure disorder DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Augusto P. Rodriguez			TITLE (SPECIFY) Deputy MEDICAL EXAMINER			DATE SIGNED 10-17-83		
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez M.D.			ADDRESS 5009 Rayburn Ct., Temple Hills, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/14/83		23c. NAME OF CEMETERY OR CREMATORY St. Mary Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany Maryland		
24. FUNERAL DIRECTOR Leasure-Stein Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR OCT 19 1983		25b. REGISTRAR'S SIGNATURE John J. Carver		
NAME 230 Baltimore Ave.				ADDRESS Cumberland, MD 21502				

